CHIP/Primary Care Plan/Limited Medicaid Plan Comparison

Benefit Description	*CHIP[A,B]*	*Primary Care Plan [Waiver]*	*Medicaid Plan [Waiver}*
Office Visit	A – $5 co-pay per visit B – $10 co-pay per visit	$5 co-pay *(Co-pays do not apply to preventive and immunization service)*	$3 co-pay
Urgent Care Center Visit	A – $5 co-pay per visit B – $10 co-pay per visit	$5 co-pay	$3 co-pay
Immunizations and Well Care Exams ***(or Well Child)***	No co-pay, plan pays 100% for A & B	No co-pay	No co-pay
Emergency Room Visit	A – $5 co-pay for emergency B – $30 co-pay for emergency	$30 co-pay per visit	$6 if non-emergent visit
Pre-Existing Condition Waiting Period	No waiting period for A & B	None	None
Laboratory	A – Plan pays 100% B – Per lab: if less than $50 plan pays 100%, more than $50 plan pays 90%	No co-pay for lab services under $50; 5% co-insurance for services above $50	No co-pay
X-rays	A – Plan pays 100% B – Per x-ray: if less than $100 plan pays 100%, if more than $100, plan pays 90%	No co-pay for lab services under $100; 5% co-insurance for services above $100	No co-pay
Out-Patient Hospital	A – Plan pays 100% B – Plan pays 90%	Not covered	$3 co-pay
In-Patient Hospital	A – Plan pays 100% B – Plan pays 90%	Not covered	$100 co-pay each admit
Specialty Care ***(including surgeons)***	Plan pays 100% for A & B	Not covered	$3 co-pay
Hospital In-Patient Physician Visits	Plan pays 100% for A & B	Not covered	No co-pay

Anesthesia	Plan pays 100% for A & B; General anesthesia for dental covered up to age 5	Not covered	No co-pay
Ambulance	Plan pays 100% for A & B	No co-pay	No co-pay
Non-Emergency Transportation	Not covered	Not covered	Not covered
Medical Equipment and Supplies	A – Plan pays 100% B – Plan pays 80%	10% co-insurance of allowed amount	No co-pay
Dental Services: • **Cleaning, exam, x-rays** • **Fluoride & sealant** • **Cavity fillings** • **Space maintainers** • **Pulpotomies** • **Extractions**	A – Plan pays 100% B – Plan pays 100% for cleanings, exams, x-rays, fluoride and sealant; Plan pays 80% for space maintainers, fillings, extractions and pulpotomies	No co-pay for cleaning, exam, sealant and fluoride; 10% co-insurance for fillings, extractions, x-rays, bitewing, maintainers, pulpotomy;	No co-pay
Hearing Screening	Plan pays $30 per child with limit of one screening every 24 months	Amount above $30 not covered	Amount above $30 not covered
Vision Screening	Plan pays $30 per child for eye exams, limit of one exam every 24 months	Amount above $30 not covered	Amount above $30 not covered
In-Patient Mental Health and Substance Abuse	A – Plan pays 100% for 30 days per plan year B – Plan pays 90% for the first 10 days; 50% for the next 20 days; limit of 30 days for per plan year	Not covered	30-day stay maximum per year *(a lower level of care may be substituted at a rate of one out-patient visit in lieu of each in-patient day)*
Out-Patient Mental Health and Substance Abuse	A – $5 co-pay for each visit; limit 30 visits per plan year B – Plan pays 50% per visit; limit 30 visits per plan year	Not covered	$3 co-pay per visit; 30-visit max
Physical, Occupational and Chiropractic Therapy	A – $5 co-pay per visit; limit 16 visits per plan year (combined) B – $10 co-pay per visit; limit 16 visits per plan year (combined)	Not covered	$3 co-pay per visit *(includes limited speech therapy and podiatry)*

Home Health/Hospice	Plan pays 100% for A & B	Not covered	No co-pay
Prescription Drugs	A – $2 per Rx on approved list B – $4 per Rx on approved list	$5 co-pay per Rx for generic and brand-name drugs on approved list; 25% co-insurance of allowed amount for brand-name drugs not on approved list	$2 co-pay per Rx
Out-of Pocket Maximum	A – $500 B – $800	$1,000 per enrollee/year	$500 per enrollee/year

[A] – Applies to families with income is at or below 150% of the Federal Poverty Level
[B] – Applies to families with income from 151% to 200% of the Federal Poverty Level